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Health Care Facility Renewal Application

As defined in section 3701-83-04 of the Ohio Administrative Code

Facility ID # 1014AS

Please print legibly in ink or type

1. Facility Name PLANNED PARENTHOOD BEDFORD HEIGHTS REGIONAL MEDICAL CENTER		
2. Address 25350 ROCKSIDE RD.		Suite
3. City BEDFORD HEIGHTS	4. Zip 44146	5. County CUYAHOGA
6. Phone Number (440) 232-4732	7. Fax Number 4 (440) 374-4969	
8. E-mail Address		

Mailing address, if different from above

9. Name KATHY CRAWFORD		
10. Address 206 E. STATE ST.		Suite
11. City COLUMBUS	12. State OHIO	13. Zip 43215

14. Renewal application type

Ambulatory surgical facility Freestanding birthing center

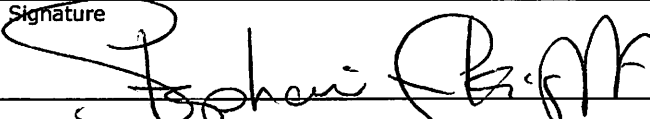
Freestanding dialysis center Freestanding inpatient rehabilitation facility

15. Has there been a change in this facility's capacity? If yes, explain	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
16. Has there been a change or update to this facility's most recent accreditation status report or findings? If yes, explain and provide a copy of the most recent accreditation inspection report and findings, unless the department has been previously notified. Explanation:	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
17. Has there been a change in ownership?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
18. Has there been a change of onsite administrator? If yes, name	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
19. Has there been a change of medical director or individual responsible for the provision of health care services? If yes, name <u>DR. TIMOTHY KRESS</u> License/certification # <u>35.060555</u>	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes

<p>20. If the owner(s), administrator or medical director has changed, has the new individual(s) been convicted of any criminal activity or been involved in a civil judgment or administrative adjudication for an offense related to the provision of care or bearing a direct or substantial relationship to the job responsibilities?</p> <p>If yes, provide the individual's name and give a full explanation stating the charge(s), date(s) and disposition on a separate page.</p>	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
<p>21. Has the owner(s), administrator or medical director been affiliated through ownership or employment with any of the facilities listed in rule 3701-83-04 (A)(1)(c) of the OAC within five years prior to the date of this application?</p> <p>If yes, provide the individual's name and list the name(s) and address(es) of the facilities on a separate page.</p>	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes

I affirm that to the best of my knowledge and belief, the answers provided herein and all accompanying materials are true and correct. I understand that section 3702.30 of the Ohio Revised Code and paragraph (E) of rule 3701-83-04 of the Ohio Administrative Code require the owner to inform the Director, in writing, of any changes in the information contained in the statement of ownership set forth in the initial application and any change in accreditation status, no later than 30 days after the change occurs.

I certify that I am an owner of the facility or the authorized representative of the owner.

Print/type owner's or representative's name <i>Stephanie F. Kight</i>	Title <i>CEO</i>
Signature 	Date <i>9/19/13</i>